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ABSTRACT

Elementary schools, junior high schools, high schools, and district offices were visited in three medium sized urban areas to explore the ways in which assessment systems for handicapped children are structured and managed. Conversations with teachers, counselors, diagnosticians, and administrators focused on reasons for delays in case processing which can cause backlogs in evaluating students for special education eligibility. Three aspects of case processing are briefly addressed: referral screening, case coordination, and quality control. Approaches taken by the three school districts in these areas are compared and contrasted in light of the effect each system's adaptations appeared to have on the efficiency of the assessment process. Effects on staff morale were also noted. (Author)

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VERIFICATION OF PROCEDURES TO SERVE HANDICAPPED CHILDREN

Final Report:
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ABSTRACT

Elementary, junior high, high schools and district offices were visited in three medium-sized urban areas to explore the ways in which assessment systems are structured and managed. Conversations with teachers, counselors, diagnosticians, and administrators focused primarily on reasons for delays in case processing which can cause backlogs in evaluating students for special education eligibility. By looking at the organization of assessment services from a systems perspective, a unique insight into the obstacles and corresponding adaptations was gained.

Three aspects of case processing are briefly addressed in this paper: referral screening, case coordination, and quality control. The approaches taken by the three school districts in these areas are compared and contrasted in light of the effect each system's adaptations appeared to have on the efficiency of the assessment process. An important side effect, staff morale, was also noted in conjunction with some features of assessment systems. Where adaptations appeared to either negatively or positively affect staff morale, these consequences are also discussed.

CASE BACKLOGS AND THE ADAPTATION OF EDUCATIONAL SYSTEMS

Since its enactment in 1975, advocates and critics of P.L. 94-142 have turned their attention to its implementation and impact on handicapped children. Practices for evaluating students' special needs continue to receive careful scrutiny. One significant concern in this regard is the existence of "backlogs" in the evaluation and placement process. This paper explores some of the organizational factors that appear significant with respect to case backlogs: processes that affect a school system's ability to evaluate students' special needs with minimal delay. An organizational or systems perspective is useful for this purpose. Such an approach looks at the interrelated elements of a system, such as its resources, basic structure, division of responsibility, and the deployment of personnel, and at how these elements are brought together to accomplish specific purposes.

The issues involved in service organization and case backlogs are numerous and complex. Only three processes of concern to educational managers are discussed here: referral screening, case coordination, and quality control. These processes are explored because each can clearly affect time lines for case processing. While isolating these evaluation components is artificial, managers must often focus their attention on parts of a system in order to affect the sum total.

The purpose of this paper, then, is to highlight several key aspects of evaluation systems, to explore the adaptations that each system has evolved, and to examine their impact on minimizing delays in case processing. The examples discussed in this paper are derived from visits to school districts in three moderately-sized cities. A two-person team spent two weeks at each site discussing case processing procedures, staff practices, and delays in the evaluation process. A total of 94 educational personnel involved in various ways with evaluation activities participated, including teachers, counselors, diagnosticians, and school and district administrators. Urban districts were visited because they are believed to be more prone to have waiting lists and logistical problems due to their larger size. Medium-sized districts, however, are not so complex organizationally as to obscure the central issues. In addition, the particular sites visited offered opportunities to learn about the absence as well as the presence of case backlogs for evaluation.

It is important to note that descriptions of some of the activities in the three districts are included simply to illustrate considerations meriting attention. Every school system is unique, and generalizations cannot be made from incomplete pictures of the experiences of three educational systems. Issues are raised here only as points of departure for managers concerned with adapting evaluation services to minimize case processing delays.

The Nature of the Problem

That backlogs in evaluation and placement are a growing concern in the educational community is evident from recent literature. Delays in case processing, and consequent waiting lists for evaluation, were found in all sites of one study on the implementation of P.L. 94-142 (Blaschke, C., 1978). The presence of waiting lists was confirmed by the Bureau of Education for the Handicapped (now the Office of Special Education) (Annual Report, 1979) and was noted as a problem in the Inspector General's report on education for the handicapped (1979). The issue of waiting lists was pointed out again at hearings on oversight of P.L. 94-142 before the House Subcommittee on Select Education during September

and October 1979. Most recently, a report by the Education Advocates Coalition (1980) underscored this implementation problem, ranking waiting lists among the ten major areas of noncompliance with the law.

The ramifications of this problem for any one handicapped student appear to vary, but may be considerable. In very large urban areas, such as New York City, waiting periods may exceed the school year; in fact, students in that city have remained on a waiting list for evaluation for as long as 2 years (Hearings, Dr. Edwin Martin, p. 306). Certainly, school districts in these sites are faced with unique complexities not typical of most school systems in this country. Because of their size, the problems experienced in major metropolitan areas are extreme, both in the number of students affected and in the length of time elapsed waiting for services. The magnitude of these problems, in turn, has focused public and judicial attention on the issue of waiting lists.

While case backlogs may not be as problematic in smaller cities, specific information about waiting lists is hard to obtain. Administrators are reluctant to acknowledge such problems and to make themselves vulnerable to litigation and Federal intervention (Hearings, Dr. Edwin Martin, p. 305). The Federal regulations stipulate a clear timeline only between evaluation and implementation of an individualized program for every child (P.L. 94-142, Section 121a.343). Although no timeline exists for the period between referral and evaluation, handicapped children who remain on waiting lists for evaluation are not receiving appropriate, Federally-mandated educational services (Hearings, Fred Weintraub, p. 98).

Concern about the problem is sufficiently widespread to indicate that waiting lists exist in many school districts, particularly in urban centers (Hearings, Dr. Edwin Martin, p. 301). Though waiting lists may not be of the same magnitude in small cities as in our largest metropolitan areas, even a waiting period for evaluation of 30 or 60 days can have a significant impact on handicapped children needing special services. The evaluation process in itself is often prolonged. State education agencies usually establish timelines for conducting

evaluations. These vary considerably; anywhere from 30 days for evaluation to 90 days may be allowed (Brandis et al., 1980). Thus, the evaluation process itself must be added to the period of time a child waits to be assessed in order to gain a picture of the actual time elapsed between referral and placement. The period of time a student is without needed services can easily amount to a school year, especially when a student is not referred until mid-way through the year.

Such circumstances also have broader repercussions. The presence of a waiting list for evaluation or placement can discourage teachers from making referrals and can result in administrative pressure on teachers to withhold referrals or other rationing techniques aimed at controlling the number of students awaiting evaluation (Weatherly and Lipsky, 1977). These indirect effects have clear implications for students with handicaps who need specialized programs of education.

Federal (and state) mandates have increased the number of different people required to participate in evaluation activities as well as the number and complexity of such activities. At the same time, efficiency of service delivery is to be maintained or improved so that backlogs in evaluation do not occur. In an effort to meet P.L. 94-142 evaluation requirements, some districts are encumbered by inefficient assessment systems; others have pursued efficiency at the cost of sound procedures. All districts have been faced with the difficult task of adapting their assessment systems to meet the complex demands of P.L. 94-142.

The Elements of the Solution

To meet service requirements for educational evaluation, school districts need resources (e.g., staff, facilities, funds) that are both sufficient and well-arranged. Where resources are insufficient, as they frequently are in any human service system, functional and efficient use of those limited resources is especially critical. Thus, the basic structure of the system, the deployment of personnel within that structure, and the way responsibilities are divided among personnel are also key variables which affect service delivery capabilities. The way

these four elements - resources, structure, personnel deployment, and division of responsibility - are arranged and applied to features of the assessment process can affect the efficiency with which the requirements of P.L. 94-142 are implemented.

The specific features of the assessment system discussed here include referral screening, case coordination, and quality control. These particular aspects of the assessment process were selected because of their potential impact on delays which can cause case backlogs. The presence or absence of these features can impact efficiency. More importantly, where these features are present, their effect upon case processing is in turn affected by the four elements discussed above.

Every school system is different; each must deal with its own constraints and capitalize upon its unique strengths. There is no formula for a perfect assessment system nor one right way to evaluate students. By looking at pieces of the process (e.g., referral screening) and the organizational elements found in those pieces (e.g., deployment of personnel), educational managers can decide for themselves the most appropriate way to arrange their assessment systems.

The remainder of this paper describes aspects of three school districts' assessment systems in light of their apparent effect upon efficiency of case processing. Where applicable, the resources, structure, staff deployment, and assignment of responsibilities are discussed for each district under each assessment-related activity. Finally, staff morale also appeared as an important side effect of different assessment arrangements. Positive and negative staff attitudes toward their roles in the assessment process are noted where found.

Referral Screening

When referrals for student evaluation are received, some type of review and decision process generally takes place before any diagnostic activities are initiated. Such review may involve routine assignment of the case to the responsible staff person; checking the form to ensure all necessary information is included; and/or more deliberate consideration

of whether special education evaluation is warranted. In this last instance, a thorough screening process is used to determine whether the problems prompting the referral could be addressed through alterations in regular educational programming first, before more specialized diagnostic and psychometric information is needed. Such an approach ensures that problem solving focused on mainstream education precedes consideration of special placements, while at the same time controls the use of specialized diagnostic resources so that they are available, with minimal delay, when needed.

One district using a formal referral screening process had an accuracy rate of over 90 percent; that is, nearly all students who were determined to need formal evaluations were found to be handicapped and in need of special education services. The structure of this process was a committee comprised of the principal, teachers, counselor, and sometimes the nurse. These committees screened referrals and developed alternate approaches to resolving problems for students not warranting evaluation. To discriminate cases appropriate for more specialized assessment, all referred students were screened for vision and hearing problems, and a meeting was held with parents to inventory behavioral, health, and social information. Resource utilization was maximized by an emphasis on adapting regular education options to meet the student's needs. School staff encouraged exploration of such options, including individualizing classroom approaches and rearranging schedules. Efficient deployment of personnel was accomplished by drawing upon district special education specialists as consultants in developing regular classroom techniques tailored to the student's apparent learning and behavioral needs.

Principals were assigned primary responsibility for ensuring that their students were tested and served appropriately. They were also designated as the chairpersons for screening committee meetings. Counselors, in turn, were delegated initial referral and referral screening committee scheduling responsibilities. Perhaps because referral screening committees were active and met routinely in each school, and because written guidance in the form of a handbook was

provided, these committees were able to meet on short notice and accomplish their duties in one to two weeks per case. An estimated 1/2 to 2/3 of the student referrals were screened out of formal evaluations through this process, thus helping to reduce diagnostic case loads and potential backlogs for services.

The screening process in another district was less developed and less effective. There were no active committees formed to handle referral screening, thus no structure for the process existed. In general, counselors were usually assigned responsibility for screening referrals and determining which students they would test and which would be referred to a diagnostic center. Counselors were unclear about the criteria for decision-making, however, and they felt pressured by teachers to proceed with evaluation. Without a structured process (i.e., formal committee), screening decisions could not be jointly made; thus, referral screening had a tendency to become personalized and subject to pressures from individuals. The result appeared to be lower staff morale and formal evaluations for most students referred. In this district, approximately 12 percent of the students receiving assessments were found to be ineligible for special education services. Although this figure is by no means excessive, evaluations of ineligible pupils exacerbated the already existing backlog for assessment services.

Deployment of personnel was theoretically similar to that of the first district: specialists (from diagnostic centers) were available for consultation concerning educational programming for students eligible and ineligible for special education services. In practice, however, the centers were rarely used during referral screening because the specialists were too busy conducting assessments. The effect of this situation was that regular education resources were not systematically explored prior to evaluation.

The concept of referral screening was rejected, on the other hand, in another school system. Here it was felt that psychometric testing was always appropriate when requested. Formal evaluation was seen as a relatively quick way to obtain valuable information about student needs,

which could then be used to determine whether regular program adjustments or special placements were appropriate. At this district, there was an expressed concern that referral screening could result in denial of services.

Although the vast majority of students tested were found ineligible for special education (more than 80%), this system was able to conduct evaluations on all students referred without backlogs for assessment. Diagnostic resources in this district were sufficient to handle a relatively low referral rate without exceeding their 40-day case processing time line. If referral rates should increase, however, unrestricted use of these diagnostic services could overload staff capabilities, resulting in delayed evaluations and possibly in waiting lists for services.

Optimally, referral screening helps to avoid reliance on special education as the answer to problematic classroom situations and to minimize overloads on diagnostic staff that can result in waiting lists for evaluation. To be effective in this, however, referral screening must emphasize and have available the resources of varied educational strategies and personnel deployed such that they can provide consultative services. Without other choices, referral screening would be ineffective in reducing unwarranted use of special services. A formal structure that allows joint decisionmaking also appears to facilitate the morale of staff involved in screening by removing an individual from sole decision making and thus personal pressures from referring teachers.

The danger with referral screening is that it could become simply a mechanism for arbitrarily limiting evaluation caseloads; students who need specialized services would not receive them if they were denied evaluations. The potential for liability of denying services was a significant factor in rejecting screening processes at one district. To prevent such problems, referral screening must constitute a problem solving process that offers strategies for assistance, monitors the effectiveness of those strategies, and when indicated, reconsiders the use of specialized diagnostic services. To accomplish this effectively,

coordination of activities and the people involved in them must take place; this aspect of the assessment process is discussed in the following section.

Case Coordination

Case coordination is the organization and management of information, people, and activities involved in any given case throughout the course of the assessment process. It involves scheduling testing, convening meetings, and compiling and documenting information. Because many people are often involved in a case and a myriad of tasks must be performed, case processing is vulnerable to fragmentation. Where coordination is lacking, the potential for delays prior to actual testing is heightened. Added to evaluation backlogs, this further extends the time a student must wait to receive services.

The deployment of personnel and assignment of responsibilities were key considerations in case coordination. In particular, the number and the type of people involved in case management and their preparation for this role appeared to significantly affect the extent to which delays in case processing could be avoided. The morale of staff involved in case coordination was also related to the degree to which they felt prepared to perform this function, the support they received, and the constraints this role imposed on performance of their other duties. The following section looks first at the role of a case manager and then moves on to the particular activities involved in case coordination.

The Case Manager

All three districts visited deployed counselors, to varying extents, as case managers. In the district with the fewest case processing delays, however, all coordination tasks were standardized and assigned solely to counselors in each school; case management duties were not shared, but performed by one individual associated with the case. This arrangement had several advantages. First, duplication of effort was avoided as was the problem of tasks not getting done because of confusion over who was to perform them. Second, centralizing responsibility for a

case appeared to facilitate the case manager's investment in timely processing. That is, where one person was both responsible for meeting time lines and for performing all case coordination activities necessary under those time lines, efficiency seemed to be heightened. Where responsibilities were diffuse--shared among several persons--commitment to processing without delays was also diffuse.

The third advantage of this arrangement of deploying staff and assigning responsibilities was that training personnel for their roles was facilitated. Case coordination activities were addressed in counselor orientation meetings and in regular group meetings of counselors. Such sessions provided role clarification and peer support. When case management duties were divided among different types of staff (as they were in other districts), it was more difficult to provide focused training; teachers, in particular, had less freedom to participate in training/meetings.

In the other two districts, counselors performed some, but not all coordinating activities. Responsibilities were shared with teachers and diagnosticians. Delays occurred, under these arrangements, due to duplicative efforts and oversights. For example, meetings were sometimes scheduled by various teachers simultaneously for different cases, resulting in time conflicts for personnel required to attend each meeting. Occasionally, special education staff were not notified of meetings. Thus, the division of responsibility for case coordination can result in fragmentation and subsequent delays. Case managers appeared to be most effective when all coordination responsibilities were assigned to one individual, rather than shared with others.

One drawback to this strategy, however, was the time demands placed upon the case manager/counselor. Where tasks were centralized and not delegated or shared, counselors were increasingly unable to devote sufficient time to their other responsibilities. This problem was beginning to cause some degree of dissatisfaction among staff.

Test scheduling

Arranging the dates for testing and determining the priorities among cases to be assessed is an important activity involved in case coordination. The efficiency with which these tasks can be carried out is in turn affected by the authority that is delegated with case manager duties and the location and contact between staff. When case managers do not schedule diagnostic staff time, continuity is lost. As physical distance between the case manager and diagnostician increases, coordination becomes more difficult. Finally, if there is no regular contact between case managers and diagnosticians, the assessment process tends to break down causing delays and potential backlogs. When this occurs, staff morale is affected adversely.

In one district, specialized diagnostic staff teams visited assigned schools on a regular basis to observe and test students. The case managers in the schools scheduled the time of the diagnostic teams during their visiting days, based on case priorities and the schools' caseload. Deployment of diagnostic personnel, then, was done so that each school became familiar with its diagnostic team and contact was regular. Case managers were assigned responsibility and delegated the authority to schedule testing themselves. This arrangement facilitated the case managers' coordination of each case, by allowing advance planning and preparation based upon their decisions concerning students to be tested. It also freed the diagnosticians from these administrative duties, allowing them to spend more time testing students. The use of diagnostic teams in this district was also an indication that diagnostic resources were sufficient to allow such deployment. The result of this combination of arrangements was an efficient and workable process for scheduling evaluations of students.

Another district assigned responsibility for scheduling assessments to the diagnosticians performing them. The potential lack of continuity and coordination caused by moving this task out of the case manager's domain was compensated for, however, by similar deployment of diagnosticians: regular visits to each school. Thus, personal contact

was routine among staff involved in cases. Again, specialized resources devoted to assessment, i.e., diagnosticians (who were either psychologists or psychometrists), were sufficient to allow this regular contact. Delays in case processing did not appear to occur under these circumstances.

In the third district, deployment of specialized diagnostic staff was centralized and physically removed from case managers and other school building staff associated with cases. Diagnostic centers in the area provided specialized evaluation services; students were transported to the centers, rather than center staff going to the schools. When a student was referred to the center for assessment, moreover, the case manager ceased to have immediate responsibility and authority over the case. The center handled all aspects of cases (scheduling, documentation, etc.) until evaluations were completed. In this transfer of responsibility, however, the specific person responsible for coordination was not clear. There was no regular communication between the center and the school/case manager, so there was no way to monitor the status and progress of assessment activities.

Finally, the abrupt interruption of coordination activities was exacerbated by the long amounts of time students spent under the center's auspices. It was not clear whether delays were caused by insufficient resources at the centers or if the arrangement of those resources was dysfunctional. Regardless of why, backlogs had developed at the centers, causing students to wait several months for services. Thus, not only was the case manager removed from major case activities, but this suspension of involvement could last for some time. This situation affected both the efficiency of the assessment system and the morale of school building staff involved in cases. The elapsed time for processing students was lengthy, often 3-4 months from referral to completed assessment. Combined with the shifts in responsibility and the lack of contact with diagnostic centers, case managers felt demoralized and teachers were discouraged by the loss of momentum.

In an effort to resolve some of these problems, the designated counselors/case managers in the schools were assigned the additional responsibility of testing mildly involved students. This arrangement had helped somewhat in reducing backlogs, but further constrained the time remaining for the counselors' other duties and was beginning to impinge on the performance of case manager duties as well.

Convening meetings

At several junctures during the assessment process, meetings may be held to discuss cases. A variety of persons, within and outside a school building, may attend. One major coordinating activity, then, is to schedule meetings at the convenience of participants and to notify all involved. It is especially important that key personnel are in attendance, since failure to appear can result in cancelling the meeting and additional time spent trying to reschedule. Each time this occurs, the assessment process is delayed. Parents often pose problems in this regard, but district staff/diagnostician attendance was also a difficulty in some instances.

Where the counselors/case managers had full responsibility for their cases, they also scheduled meetings and notified participants. Where case management responsibilities were shared, teachers and counselors both made meeting arrangements. Unless the division of labor was clearly specified, i.e., who would call whom, oversights occasionally occurred and key personnel would not be notified of the meeting. In the two districts where diagnostic staff made regular visits to the schools, determining schedules and contacting participants was facilitated. When the days and times diagnostic staff would be in the building were known, meetings could be scheduled during those times, and the diagnosticians could be notified in person. Where diagnostic staff required to attend meetings were removed from the school, scheduling took longer and was more difficult to arrange. District/area staff attendance at meetings also presented problems causing delays. In the district where counselors were assuming assessment responsibilities for mildly handicapped students, special education supervisors at the area level also attended

meetings. This deployment of personnel served a quality control function, but had some negative repercussions. Resources (i.e., the number of area supervisors) were too limited to allow attendance at the many meetings in the various schools. Area supervisors were often occupied with their other responsibilities, creating severe scheduling difficulties. The effect of this situation was that meetings were delayed until the supervisor could attend, or they were held without the supervisor, thus circumventing monitoring controls. Finally, school building staff resented the intrusion on their authority; this feeling was exacerbated by the delays caused in trying to schedule meetings so the supervisor could attend.

Similar problems were created in another district which also deployed district staff (program supervisors) to attend case conferences. Lack of resources and other responsibilities created delays in scheduling meetings. In some instances, approval from the supervisor was obtained after the meeting through a paper review of the case.

The third school system did not assign district personnel the responsibility of attending routine case conferences, but instead deployed them as monitors of case documentation. Regular review of test reports and eligibility decisions by diagnostic supervisors served to provide quality control without overburdening resources. Routinization of this document review facilitated the efficiency with which it was carried out.

Finally, the problem of parent participation in meetings was experienced in all three districts. Parents were sometimes reluctant to attend meetings or, because they worked, arranging a convenient time for conferences was difficult. Where community awareness and activism was growing, a changing structure for parent meetings was forseen, with more meetings and more participants (e.g., lawyers, advocates, private diagnosticians). In areas of minority concentration, other specialized resources were needed (e.g., bilingual staff). Parent involvement in the assessment process had not been addressed to the satisfaction of any of the districts visited; it was an area targeted for future problem solving.

Compiling and documenting information

Another important activity in case coordination is to ensure that all necessary information has been collected (e.g., test results, school records, family history, etc.) prior to meetings. Case processing is often delayed when meetings are called before sufficient data have been amassed. In these instances, decisions may be based on inadequate or outdated information, or the meeting may be cancelled and rescheduled when completed data are ready. Documentation (of referrals, meeting outcomes, and diagnostic reports) can also contribute to lengthy waiting periods before the next steps in the assessment process can be taken. Thus, this last coordinating activity--compiling and documenting--can potentially be a key delay variable.

Several activities and arrangements already discussed facilitated the compilation of information in one district. In this school system, the formal structure of a referral screening committee also functioned to review case data for completeness prior to evaluation. The case manager was responsible for all aspects of preliminary information gathering, including accessing academic and attendance data and checking for prior evaluation information. This deployment of staff had the added advantage of relieving teachers from this burden, thus referrals were not discouraged because data gathering on the part of the referring teacher was minimized. Effective utilization of teacher resources was realized in the process.

Documentation of diagnostic findings was extensive and carefully monitored in this district. To avoid delays caused by waiting for final reports, a handwritten summary was provided to school staff within 1-2 weeks of evaluation. This synopsis furnished recommendations for teaching activities that could be used in the regular classroom to help the student until a final placement decision was made. This strategy had positive effects upon staff morale by giving teachers prompt and practical feedback on their referrals.

Responsibility for compiling case information varied in the other two districts. Sometimes the counselor/case manager took care of this, and other times the diagnosticians and/or teachers shared responsibility for assembling student information. Although this lack of standardized approach could make case processing prone to delays due to confusion and missing information, neither district had as yet experienced severe problems because of this.

Documenting information, in particular diagnostic reports, was time consuming for all three assessment systems. While the district discussed earlier produced summary reports for rapid feedback, no similar strategy was found elsewhere. A major factor causing delays in producing final diagnostic reports was the lack of clerical support for typing. Diagnostic reports could be held up for several weeks, simply because clerical resources were insufficient. This delay, in turn, postponed eligibility meetings, which could not be conducted until the diagnostic report was available.

In summary, case coordination is facilitated at several stages by strategic deployment of personnel (such as regular school building visits by diagnosticians); careful allocation of responsibility (such as centralizing all case coordination activities under a case manager); efficient resource utilization (such as freeing up teacher and diagnostician time by relieving them of major administrative tasks); and by multi-purpose structures (such as referral screening committees which monitor completeness of student data). In turn, the greater the coordination, the more efficiently cases can be processed, and the fewer delays in delivering services.

It is important, however, that mechanisms for monitoring assessment activities and products are also present to ensure that efficiency does not adversely affect quality. This aspect of evaluation systems is discussed below.

Quality Control

Efficiency is one standard by which assessment systems can be monitored; by this criterion, a system which processes cases with minimal delays and within state and Federal time lines meets this standard. Such a view concentrates on the process, but overlooks the product. For a total perspective, the effectiveness of those outcomes must also be monitored. Thus, compliance with state and Federal guidelines concerning protection in evaluation procedures must also be checked. While monitoring the efficiency and quality of assessment services is a necessary safeguard, this activity in itself can also cause delays. Multiple approvals of eligibility decisions, for example, can delay case processing, especially when routing of documents crosses buildings. Conversely, without monitoring of the system, there is no way to identify problem areas and thus to institute corrective actions when needed.

At the case level, quality control may be applied by monitoring the progress of individual cases. At a higher level, supervisory review and approval requirements serve as checks on the system. At the district level, statistics on the assessment process may be amassed and analyzed to provide an overview of the system as a whole.

In all districts, the responsibility for tracking individual case progress was part of the case manager role. Where case management duties were shared among different staff, accountability was also shared. None of the districts, however, delegated the corresponding authority to institute corrective actions to those held accountable for quality control at the case level. Staff either had to report problems to the appropriate authority or attempt to resolve difficulties informally. Sometimes identifying a problem was sufficient to generate needed actions. This seemed to be the case most often when one person was in charge of case management and monitoring. In these instances, then, the potential for resolving delay-related difficulties was greater.

Where responsibilities and accountability were shifted among personnel depending upon the stage in the assessment process, staff were

frustrated by the perceived lack of responsiveness to reported problems. In these situations, the ability to control or influence activities on a case were fragmented and weakened by the diffusion of duties spread among several staff members. Those personnel empowered to institute corrective actions also were diffused, depending on the organizational structure and reporting lines of authority.

The most extreme example of this occurred in one district, where counselors, teachers, and diagnosticians all shared case management activities, but each reported to a different supervisor in different departments. Thus, supervisors experienced problems in taking corrective actions that mirrored the difficulties experienced by those requesting assistance.

Supervisory review and approval of diagnostic information, another quality control activity, could be time consuming for similar reasons. In one district, several departmental supervisors in different buildings were required to review and approve documentation prior to eligibility meetings. The deployment of staff in separate physical facilities, each with similar responsibilities for quality control, impeded the efficiency of case processing. Much time was lost simply in the transfer of documents between buildings. Meanwhile, the disposition of cases was held in abeyance pending approval. The organizational structure here was dysfunctional: assessment duties were conducted by different staff under different departments (e.g., counselors, diagnostic centers), thus necessitating multiple departmental involvement.

In contrast, another district had centralized their diagnostic services and thus their diagnostic approval functions as well. This provided more time for a thorough review of diagnostic reports. Numerical calculations, diagnostic interpretations, and the language used in reports were screened carefully by several supervisors who were all deployed in the same building and assigned complementary responsibilities. Supporting this arrangement was a functional organizational structure of the district: diagnostic activities were under the domain of one department.

Finally, the third district did not review or approve evaluation reports. There was a great deal of confidence in the expertise of the diagnostic staff so this type of monitoring was felt to be unnecessary.

At the largest, system-wide, level, all three districts seemed to be at early stages in developing procedures for monitoring the whole assessment process. Statistics on referrals, assessments, and elapsed time for cases were not routinely collected and aggregated at the district level. To do this manually would be a massive effort. Automated information systems were being explored or implemented in all three districts. The resources for such initial purchases of equipment will be considerable, however. As yet, the three districts were not to the point of determining who would have responsibilities for the management information systems, where in the overall structure this system would be, or how staff would be deployed within that structure.

Use of technological advances, though still in its infancy in these districts visited, could help educational managers to spot case delays and take action in minimizing the build-up of case backlogs. In the meantime, however, personal review and approval of reports and monitoring of progress on individual cases by case managers were the primary quality control mechanisms used. Where deployment of staff crossed buildings, where the organizational structure diffused assessment staff across departments, and where responsibilities for monitoring were divided among staff, quality control procedures, ironically, could cause delays in case processing. Case conferences could be held up pending receipt of approved reports. The ability to institute corrective actions that would speed up the assessment process was impeded by the lack of case manager authority and the dispersement of supervisory personnel.

Summary

Referral screening, case coordination, and quality control are support features of the assessment process which can facilitate the efficiency and effectiveness of service delivery. Because they are key junctures in this process, however, they can also cause delays in case

processing if they are dysfunctional. Each of these assessment-related activities has been examined in terms of the resources, structure, division of responsibilities, and deployment of personnel involved, where applicable. By illustrating the variations found in three school districts, and the effects upon assessment time lines, some indication of the more functional arrangements can be made. Finally, because the assessment process is carried out by people, the morale of staff is another factor which enters into the operation of the system. The effect of various arrangements on staff attitudes, therefore, has also been addressed.

In general, referral screening appeared to be an effective mechanism for controlling the use of specialized diagnostic services and preventing case overloads. A formal structure for this activity, in the form of a school-based committee, helped prevent peer pressures from being exerted to force evaluations for each referral. By focusing on regular education classroom adaptations before special education placement, referral screening also encouraged efficient resource utilization.

Case coordination appeared to be most effective when the responsibility for all coordinating activities was assigned to one individual, rather than divided among several staff. Deployment of diagnostic staff such that they made regular visits to schools, facilitated coordinating activities, especially scheduling tests and meetings. To accomplish this, however, assessment systems also needed sufficient resources, that is, enough diagnosticians to allow such an arrangement. Sufficient clerical resources were another factor in minimizing delays in typing diagnostic reports needed for case conferences.

Quality control tended not to slow down the assessment process when the organizational structure centralized diagnostic staff and supervisors. Deployment of those performing review and approval functions in the same building reduced delays caused by transmittal of documents.

Finally, staff morale was positively affected when preparation for assessment-related responsibilities was given, when paperwork involved in a referral was minimized, and when feedback on referrals was timely.

Conclusion

The mandates for assessment under P.L. 94-142 present complex challenges for educational managers. Although this paper has concentrated primarily on reasons for, and approaches which appear to minimize, delays in case processing, providing quality services is an equally important aspect of the P.L. 94-142 goal. In adapting assessment systems so that they are in compliance, then, both considerations of efficiency and quality must be incorporated.

The examples in this paper may provide managers with ideas for improving their assessment system or may flag potential problem areas for individually designed resolution. Discussion of the assessment process has been broken down into related activities (e.g., case coordination) and component parts (e.g., resources) to facilitate such consideration.

Implementation of desired adaptations, however, is not necessarily a simple process. Some aspects of efficient service delivery for example, appear related to the overall organizational structure of district-wide diagnostic services. Instituting such an adaptation clearly would require major changes. Other facilitating aspects of assessment systems are smaller in scope, but nonetheless difficult to implement.

Research on innovation and change in educational systems offers some suggestions that are applicable to those seeking to adapt assessment processes for greater efficiency. One such study (Greenwood et al., 1975) found that successful implementation of educational innovation was characterized by a process of "mutual adaptation." That is, the innovation must be adapted to suit the needs of the people affected, while the people affected must learn to adapt to the changes required of them by the innovation. Furthermore, effective adaptation was facilitated by a number of features including:

- administrative support at all levels of the system;
- ongoing planning achieved through regular, frequent meetings;
- open channels of communication; and
- administrative flexibility.

Delays in case processing can be minimized, but this will require the concerted efforts of staff and managers alike. Through selective adaptation, creative innovation, and sheer determination, assessment systems can be designed to deliver quality services with maximum efficiency. When this is accomplished the true spirit of P.L. 94-142 will have been met.

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